HRA Claim Form

Please follow the steps below to thoroughly and accurately complete this form.

Employee Name: _____

Last 4-Digits of SSN: _____

Employer Name: _____

Email: _____

Fill out for change of Address only!

New Address: _____

City: _____

State, Zip: _____

Phone: _____

Please list only expenses that are eligible for this plan. Attach copies of Explanation of Benefits (EOBs) supporting each expense item listed below.

Note: Invoices, cancelled checks or credit card receipts are not valid forms of documentation.

Eligible Expenses To Be Reimbursed

Date(s) of Service	Patient Name	Description	Claim Amount
Claim Total			$

READ CAREFULLY!

The undersigned participant authorizes ESG to review all submitted expenses for purposes of this reimbursement. By signing this form, I acknowledge that my statements in this request for reimbursement form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. *IRS regards the date incurred as being when the service is rendered, not when you pay the bill*. I certify that these expenses have not been previously reimbursed under this or other benefit plans and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Account to be reduced by the amount(s) requested. The undersigned further understands that no medical expense tax deduction is permitted for amounts for which reimbursement is made.

Employee Signature: _____ **Date:** _____

Retain the original receipts and a copy of this form for your records. ***For Tax Purposes*** *– Use only for expenses incurred in the same plan year for yourself or members of your family who are dependents.*

Email completed form along with copies of all EOBs to customerservice@esgcorp.biz